General Assembly

Raised Bill No. 1349

January Session, 2007

LCO No. **4860**

04860_____INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT ESTABLISHING THE CONNECTICUT SELECT CARE CHOICES PROGRAM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective from passage*) As used in sections 1 to 15, inclusive, of this act:

(1) "Benchmark policy" means a health insurance policy as described in section 3 of this act.

(2) "Eligible individual" means an individual who is (A) a resident of the state, (B) under sixty-five years of age, and (C) not covered by employer-sponsored insurance, except that "eligible individual" does not include an individual who has been a resident of the state for less than six months and lives in a family and household without at least one person who is employed full time in the state.

(3) "Program" means the Connecticut Select Care Choices program.

Sec. 2. (NEW) (*Effective from passage*) (a) There is established, within the office of the Comptroller, the Connecticut Select Care Choices program to provide health insurance policies, as defined in section

38a-469 of the general statutes, to ensure affordable health care for eligible individuals.

(b) The Comptroller shall arrange and procure health insurance policies for enrollees in the program. The Comptroller shall negotiate and contract with insurance companies and health care centers authorized to do insurance business in the state, in accordance with the provisions of section 38a-41 of the general statutes, to provide health insurance policies to the program. Such health insurance policies shall be approved by the Insurance Commissioner in accordance with the provisions of title 38a of the general statutes.

(c) The Comptroller shall educate state residents about the health insurance policies available under the program, by means including, but not limited to, preparation of educational materials; conducting informational sessions or workshops; contracting with nonprofit organizations and community-based organizations for outreach to hard-to-reach populations and training, consulting with and reimbursing licensed health insurance brokers for assistance in educating residents.

(d) The Comptroller shall promote the use of information technology by insurance companies and health care centers providing health insurance policies to the program, individuals applying to, enrolled in or seeking information about the program and persons providing information to the program and shall arrange for the provision of technical support, training and assistance to assure the effective use of such information technology. The Comptroller shall require each insurance company and health care center providing health insurance policies to the program to operate an electronic health record system not later than October 1, 2007, certified by the Comptroller, that meets interoperability standards established by the Comptroller, by regulations adopted in accordance with section 15 of this act, for such electronic health record systems.

Sec. 3. (NEW) (*Effective from passage*) (a) The Comptroller shall make

available to each eligible individual seeking enrollment in the program a choice of health insurance policies, affordable to most state residents, offering a wide range of benefit options, including at least two benchmark policies, as described in subsection (b) of this section. The Comptroller shall survey employer-based health insurance coverage in New England to determine the actuarial value of benchmark policy coverage.

(b) Each benchmark policy shall:

(1) Have an actuarial value that is not less than the sum of (A) the actuarial value of all coverage, excluding dental coverage, for average New England enrollees in employer-based insurance during the previous year; and (B) the actuarial value of dental coverage for average New England enrollees in employer-based insurance during the previous year; and

(2) Offer benefits including, but not limited to, office visits, inpatient and outpatient hospital care, mental and behavioral health care, including substance abuse treatment, prescription drugs, including brand name and generic drugs, maternity care, including prenatal and postpartum care, oral contraceptives, durable medical equipment, speech, physical and occupational therapy, home health care, hospice services and extended care as alternatives to institutionalization; preventive and restorative dental care, basic vision care and, as prescribed by a physician, personalized nutrition and exercise plans and smoking cessation services; and

(3) Be in compliance with the provisions of section 4 of this act.

Sec. 4. (NEW) (*Effective from passage*) (a) As used in this subsection:

(1) "Class of coverage" means single adult coverage, two adult coverage and variations of coverage with children as approved by the Comptroller; and

(2) "Designated provider" means (A) a federally qualified health

center, (B) a health center determined by the Comptroller, in conjunction with the Commissioner of Public Health, to be substantially similar to a federally qualified health center, (C) a school-based health clinic, or (D) a primary care clinic or other primary care provider designated by the Department of Public Health as comprising such an essential part of a local community's primary care infrastructure that, if members of the community could not obtain health care through such provider, such community members would lack sufficient access to primary care.

(b) Each health insurance policy under the program shall be in compliance with the provisions of chapter 700c of the general statutes, and any other applicable state or federal law, and shall:

(1) Require payment of the same premium for each class of coverage, except that personal responsibility discounts shall be offered as provided in subsection (c) of this section;

(2) Cover preexisting conditions;

(3) Guarantee issue;

(4) Cover, without cost-sharing, complete examinations for every adult and child, including all screenings and immunizations that are appropriate to the individual's age, gender, culture, race and ethnicity; and

(5) Treat each designated provider as a preferred provider to which the health insurance policy's lowest schedule of primary care copayments or coinsurance applies, except that a health insurance policy need not extend such status to a designated provider if the Department of Public Health certifies that such health insurance policy provides alternate arrangements for primary care that do not reduce access to primary care for the policy's enrollees that live in the community served by the designated provider.

(c) (1) In addition to the requirements of subsection (b) of this

section, each health insurance policy under the program shall offer a personal responsibility discount. The Comptroller shall determine the amount of the discount, which shall not be less than the average long-term health care cost savings, discounted to present value, for a Connecticut resident who avoids obesity and tobacco use for a year.

(2) To qualify for a personal responsibility discount, an enrollee shall obtain an annual medical assessment of obesity and tobacco use that determines that (A) with respect to obesity, the enrollee is not obese, or is obese and, consistent with guidelines to be established by the Comptroller, by regulations adopted in accordance with section 15 of this act, is enrolled and participating in a personalized nutrition and exercise program, or (B) with respect to tobacco use, does not use tobacco, or uses tobacco and, consistent with guidelines to be established by the Comptroller, by regulations adopted in accordance with section 15 of this act, is enrolled and participating in a smoking cessation program.

(3) If an enrollee qualifies for a personal responsibility discount, the insurance company or health care center offering the health insurance policy under which the enrollee is covered shall apply such discount to the amount of the premium owed by the enrollee under such policy. If the amount of such discount is more than the amount of the premium owed by the enrollee, the Comptroller shall pay to the enrollee the difference between the amount of the discount and the amount of the premium owed.

Sec. 5. (NEW) (*Effective from passage*) (a) Any state resident may purchase health insurance coverage under the program at the full cost for such coverage, as determined by the Comptroller, if such resident:

(1) Has not been a state resident for six months or more and lives in a family and household without at least one person who is employed full time in the state; or

(2) Is sixty-five years of age or older and is employed by, or whose

spouse is employed by, an employer that: (A) Offered employer-sponsored insurance on or before October 1, 2006, but no longer offers such insurance, and (B) would have qualified to participate in such employer-sponsored insurance in effect on October 1, 2006.

(b) Any employer may purchase either full or partial coverage under the program for a retired employee who is a state resident at the full cost for such coverage, as determined by the Comptroller.

Sec. 6. (NEW) (*Effective from passage*) (a) On and after July 1, 2008, any eligible individual, or individual purchasing coverage in the program in accordance with the provisions of section 5 of this act, may apply to the program through the office of the Comptroller or the Department of Social Services.

(b) The Comptroller shall establish a health consumer assistance program which shall be available to counsel eligible individuals and individuals purchasing coverage in the program in accordance with the provisions of section 5 of this act concerning the health insurance policies offered under the program and to enroll such individuals in the program. The health consumer assistance program may be established within the office of the Comptroller, or the Comptroller may contract with a nonprofit organization to operate such health consumer assistance program, provided such nonprofit organization is financially independent from all insurance companies and health care centers providing health insurance policies to the program and does not receive any financial benefit, direct or indirect, from an enrollee's choice of any health insurance policy under the program.

(c) Enrollees may change health insurance policies:

(1) During any open enrollment period established by the Comptroller, which shall occur at least once per calendar year; and

(2) At any other time, for good cause, consistent with regulations established by the Comptroller, in accordance with section 15 of this

act.

Sec. 7. (NEW) (*Effective from passage*) (a) On and after July 1, 2008, an eligible individual not yet enrolled in the program shall be enrolled by default when any of the following occurs:

(1) Such individual's income is reported to the Department of Revenue Services or the Labor Department;

(2) A state income tax form is filed on which such individual is listed as a member of the household; or

(3) Such individual seeks health care.

(b) When an eligible individual is enrolled in the program under subsection (a) of this section, a fee-for-service health insurance policy shall be issued to the individual until the individual chooses a health insurance policy under the program. The individual shall have a reasonable period of time, not to exceed sixty days, after being enrolled in the program to choose a health insurance policy. If the individual does not choose a policy within such time, the Comptroller shall select a benchmark policy for the individual. Such selection shall take into account, but not be limited to, the following:

(1) Maximizing continuity of care for the individual;

(2) Keeping all family members within a single plan; and

(3) Supporting benchmark plans with the best performance as to low premiums and high-quality care or positive outcomes for individuals previously enrolled under subsection (a) of this section.

Sec. 8. (NEW) (*Effective from passage*) (a) The Department of Social Services shall screen each eligible individual, or individual purchasing coverage in the program in accordance with the provisions of section 5 of this act, at the time such individual applies for the program for eligibility under Title XIX or Title XXI of the Social Security Act. Such

screening shall also determine income for purposes of establishing the amount of premium payments under the program for each such individual. Individuals shall be enrolled in the appropriate state Medicaid program or the HUSKY Plan, unless the individual objects to such enrollment. To the maximum extent feasible, relevant information shall be obtained through state-maintained or state-accessible data and through the self-attestation of individuals.

(b) Notwithstanding any provision of the general statutes, the following information shall be made available to the Department of Social Services and the Comptroller for the purposes of determining eligibility under Title XIX or Title XXI of the Social Security Act and for establishing premium payments under the program:

(1) Eligibility and enrollment information for individuals enrolled in means tested assistance programs, other then the HUSKY Plan;

(2) New hire information and quarterly reports provided to the Labor Department; and

(3) Information showing United States citizenship of individuals, including, but not limited to, information obtained from birth certificates and other vital records; and

(4) Federal information about new hires, quarterly earnings, Social Security numbers, immigration status and other data pertinent to income or other components of eligibility for Title XIX or XXI of the Social Security Act.

(c) The Comptroller and the Commissioner of Social Services shall enter into agreements with other state agencies providing or receiving information for the program. Such agreements shall require that:

(1) Such information be used only to verify or establish income or eligibility for matching funds under Titles XIX or XXI of the Social Security Act; and

(2) Each state agency providing information to the program train and monitor all staff and contractors who have access to such information and inform such staff and contractors of all applicable state and federal privacy and data security requirements.

(d) Within available appropriations, the Commissioner of Social Services shall develop and operate the information infrastructure required to conduct the screening described in subsection (a) of this section and shall take all feasible steps to maximize the use of federal funds for developing and operating such infrastructure. The commissioner, in consultation with data privacy and security experts, shall develop and implement policies and procedures that maintain data security and prevent inadvertent, improper and unauthorized access to or disclosure, inspection, use or modification of information.

(e) Any individual about whom information is provided to the program shall have the right to (1) obtain, at no cost to the individual, a copy of all such information, which shall identify the agency from which the information was obtained, and (2) correct any misinformation or complete any incomplete information. If any breach of an individual's privacy occurs, such individual shall be promptly informed of such breach and of any rights and remedies available to the individual as a result of such breach.

Sec. 9. (NEW) (*Effective from passage*) (a) On or before January 1, 2008, the Commissioner of Social Services shall submit to the federal Centers for Medicare and Medicaid Services an amendment to the state Medicaid plan required by Title XIX of the Social Security Act to extend coverage to all parents, guardians and caretaker relatives with incomes at or below three hundred per cent of the federal poverty level, as well as to any other individuals with incomes below such level who are nineteen to sixty-four years of age, inclusive, and who may be covered, at state option, through the state plan amendment.

(b) If needed to access all federal funds allotted to the state under Title XXI of the Social Security Act, the commissioner shall cover

individuals over eighteen years of age, including, but not limited to, pregnant women, whether or not such individuals are eligible for coverage under Title XIX of the Social Security Act.

(c) (1) On or before January 1, 2008, the commissioner shall submit an application for a waiver under Section 1115 of the Social Security Act, in accordance with section 17b-8 of the general statutes, to authorize the use of funds received under Title XXI of the Social Security Act for individuals nineteen to sixty-four years of age, inclusive, with incomes at or below one hundred eighty-five per cent of the federal poverty level who do not otherwise qualify under Title XIX of the Social Security Act, either under mandatory eligibility or at state option through state plan amendment. Federal budget neutrality requirements for such waiver may be met through unused uncompensated care payments to hospitals or by taking other measures, provided such measures do not result in any of the following for individuals who would have qualified for coverage under the Medicaid program, the HUSKY Plan or state-administered general assistance:

(A) Any reduction in covered services or access to care;

(B) Any increase in deductibles, premiums or other out-of-pocket costs; or

(C) Any reduction in enforceable, individual guarantees of coverage or services.

(2) If federal budget neutrality requirements do not permit extending Title XIX coverage to the individuals described in subdivision (1) of this subsection, such coverage shall extend to such individuals with incomes under the highest possible percentage of federal poverty level less than one hundred eighty-five per cent.

Sec. 10. (NEW) (*Effective from passage*) (a) Enrollees in the program shall pay the amounts provided in subsection (b) of this section for the

health insurance policy under which they are insured.

(b) (1) For a health insurance policy with a premium less than or equal to the premium charged by the lowest cost benchmark policy:

(A) If the enrollee's family income is at or below one hundred eighty-five per cent of the federal poverty level, the enrollee shall pay no premium.

(B) If the enrollee's family income is above three hundred per cent of the federal poverty level, the enrollee shall pay thirty per cent of the premium.

(C) If the enrollee's family income is one hundred eighty-six per cent to three hundred per cent of the federal poverty level, inclusive, the enrollee shall pay a percentage of the premium that shall be greater than zero per cent but less than thirty per cent of such premium according to a schedule to be established by the Comptroller, by regulations adopted in accordance with section 15 of this act.

(D) For an individual who would have qualified for Medicaid, the HUSKY Plan or state-administered general assistance under state law in effect on October 1, 2006, the premium shall not exceed the amount permitted under such law for the applicable program, increased in subsequent years based on changes to median earnings among Connecticut households with incomes at or below three hundred per cent of the federal poverty level.

(2) For a health insurance policy with a premium higher than the premium charged by the lowest cost benchmark policy, the enrollee shall pay the amount specified in subdivision (1) of this subsection, plus the amount of the difference between the premium for the health insurance policy and the premium for the lowest cost benchmark policy.

(c) Any amount paid by an enrollee to the program shall not be included in the gross income of the enrollee for state or federal income

tax purposes, except as required under Section 125 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended. Each employer in the state, whether or not such employer is subject to payment responsibilities under sections 2 to 15, inclusive, of this act, shall exclude the amount of such payments made by employees of the employer from the gross income paid by the employer to such employees.

(d) The Comptroller and the Commissioner of Revenue Services shall establish a system for automated payments to the program through payroll deductions. Automated payments shall be sent to the Department of Revenue Services, which shall forward such payments to the Comptroller. Enrollees participating in the program may opt out of payroll deduction and establish with the Comptroller alternate means of making payments to the program.

(e) The Comptroller shall adopt regulations, in accordance with section 15 of this act, establishing when enrollee payments shall be made to the Comptroller for subsequent transmittal to the health insurance companies or health care centers providing health insurance policies to the program and when such payments shall be made directly to such health insurance companies or health care centers.

Sec. 11. (NEW) (*Effective from passage*) (a) Each employer whose payroll exceeds one hundred thousand dollars per quarter for the first year the program is in effect, with such amount adjusted annually thereafter based on changes to average earnings in Connecticut, shall pay to the Comptroller quarterly base contributions, as provided in subsection (b) of this section, minus any reductions received under subsection (c) or (d) of this section. If an employer's reductions equal or exceed the amount of any quarterly base contribution, neither the employer nor the Comptroller shall be liable for the payment of such quarterly base contribution. For purposes of this section, average earnings in Connecticut shall be determined by the Secretary of the

Office of Policy and Management.

(b) An employer's quarterly base contribution shall be determined as follows:

(1) The Comptroller shall estimate annually the total amount that, together with payments from program enrollees, is needed to pay all quarterly costs for the program for that year if no employer in the state offered health insurance coverage to its employees.

(2) The Comptroller shall estimate the total amount of nonexempt payroll in the state, which shall be the total payroll in the state minus the following exempt amounts:

(A) During the first year the program is in effect, exempt amounts are for each employer, the first one hundred thousand dollars of quarterly payroll.

(B) After the first year the program is in effect, the exempt amounts in subparagraph (A) of this subdivision shall be adjusted based on changes to average earnings in Connecticut.

(3) The amount estimated under subdivision (1) of this subsection shall be divided by the total amount of nonexempt payroll determined under subdivision (2) of this subsection. Such quotient shall be multiplied by the employer's nonexempt payroll.

(c) (1) Each employer that offers employer-sponsored health insurance to its employees shall receive a reduction of the quarterly base contribution payable. The amount of such reduction shall equal the amount paid by the employer and its employees for premiums for such health insurance.

(2) (A) In addition to the reduction provided in subdivision (1) of this subsection, each employer that offers employer-sponsored health insurance to its employees may receive an efficient purchasing credit. An employer wishing to receive an efficient purchasing credit shall

provide the following information to the Comptroller:

(i) An aggregate profile of the employer's insured employees and such employees' dependents in terms of age, gender, area of residence and any other factors that may be taken into consideration in setting group health insurance rates under title 38a of the general statutes;

(ii) The amount of premiums paid for such insured employees by the employer and the employees; and

(iii) Covered benefits provided to such insured employees and the terms of such coverage, including, but not limited to, deductibles and other out-of-pocket cost sharing provisions.

(B) Taking into account the aggregate risk profile of the employer's insured employees, the Comptroller shall determine the ratio between premium payments for such employees and the actuarial value of the coverage such employees receive.

(C) Taking into account the aggregate risk profile of enrollees under the program, the Comptroller shall determine the median ratio between total payments for such enrollees and the actuarial value of the coverage such enrollees receive.

(D) If the ratio in subparagraph (C) of this subdivision is greater than the ratio in subparagraph (B) of this subdivision, the employer shall receive a proportionate credit for demonstrated purchasing efficiencies. The amount of such employer's quarterly base contribution shall be reduced by the amount of such credit.

(3) For the purposes of this subsection, on or before October first of the year previous to the year in which an employer claims to offer employer-sponsored health insurance to its employees, such employer shall demonstrate to the satisfaction of the Comptroller that such insurance is in effect. If an employer fails to make such demonstration, the employees of the employer and such employees' dependents shall be enrolled in the program as of the following January first.

(d) (1) Each employer that does not offer its employees employer-sponsored health insurance shall be credited with such employer's pro rata share of the total payments made to the program from enrollees, the General Fund and the federal government. The amount of such employer's quarterly base contribution shall be reduced by the amount of such share. Such share shall be the following fraction:

(A) The numerator shall be the amount of the employer's nonexempt payroll; and

(B) The denominator shall be the total amount of nonexempt payroll of all employers in the state whose employees are enrolled in the program.

(2) Each employer that does not offer its employees employer-sponsored health insurance and offers a workplace wellness program shall be credited for such program, based on guidelines to be established by the Comptroller, by regulations adopted in accordance with section 15 of this act. The amount of such employer's quarterly base contribution shall be reduced by the amount of such credit. Workplace wellness programs include, but are not limited to, on-site exercise facilities, employer payment of gym fees, paid exercise release time and any reasonable unreimbursed costs for outpatient health clinics at the employer's workplace.

(e) Employer quarterly base contributions shall be sent to the Department of Revenue Services, which shall forward such payments to the Comptroller.

Sec. 12. (NEW) (*Effective from passage*) (a) (1) Each employee, and the dependents of such employee, whose employer offers employer-sponsored health insurance to its employees shall be deemed to be insured under such insurance.

(2) Notwithstanding the provisions of subdivision (1) of this subsection:

(A) If an employee or a dependent of an employee is a child who qualifies for the HUSKY Plan, such child shall not be deemed to be insured under employer-sponsored health insurance. Such child shall be so insured only if a parent or other legal guardian of the child consents to such insurance in writing.

(B) If an employee receives offers of employer-sponsored insurance from more than one employer, such employee, or a parent or other legal guardian of such employee if such employee is a child, may choose which offer to accept. The Comptroller shall establish guidelines, by regulations adopted in accordance with section 15 of this act, to govern enrollment into employer-sponsored health insurance for employees who do not accept any offer.

(C) Any former employee that is offered employer-sponsored health insurance under the federal Consolidated Omnibus Budget Reconciliation Act by the former employer shall not be deemed to be insured under employer-sponsored health insurance. Such former employee shall be so insured only if the former employee consents to such insurance in writing.

(D) If an employer offered employer-sponsored health insurance to its employees on or before October 1, 2006, and the amount of such employer's current premium payments per insured employee are not less than the amount of such employer's premium payments per insured employee on or before October 1, 2006, adjusted for the medical care component of the consumer price index, an employee or dependent of such employee may decline an offer of employer-sponsored health insurance and shall not be deemed to be insured under such insurance.

(b) Any employee who qualifies under the Title XIX Medicaid program and is enrolled in an employer-sponsored health insurance policy shall receive supplemental coverage as provided in section 13 of this act.

(c) Nothing in sections 2 to 15, inclusive, of this act shall prohibit an employer or an individual from purchasing or providing health insurance or health care services in addition to those provided under the program.

Sec. 13. (NEW) (*Effective from passage*) Any enrollee in the program who is eligible for supplemental coverage under Medicaid or the HUSKY Plan shall receive such supplemental coverage. The Comptroller, in cooperation with the Commissioner of Social Services shall develop integrated, seamless procedures to ensure that such enrollees receive such coverage.

Sec. 14. (NEW) (*Effective from passage*) (a) The Comptroller shall prospectively adjust payments for each health insurance policy under the program to compensate fully for any differences between the average risk levels of the policy's enrollees and the state's nonelderly population.

(b) Within available appropriations, during the first three years of implementation of the program, the Comptroller may subsidize the cost of reinsurance premiums related to the program. The remainder of the cost of such premiums shall be paid from payments made to the program by or on behalf of enrollees.

(c) The Comptroller shall establish risk corridors and coinsurance percentages for subsidized reinsurance based on best practices from other states.

(d) On or before January 1, 2011, the Comptroller shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance and real estate, containing recommendations about future financing for reinsurance. If the General Assembly does not take action to the contrary before the end of the February, 2012 regular session, reinsurance premiums shall, for the third and each subsequent year, be paid entirely by payments

made to the program by or on behalf of enrollees.

Sec. 15. (NEW) (*Effective from passage*) The Comptroller shall adopt regulations, in accordance with chapter 54 of the general statutes, to implement and administer the Connecticut Select Care Choices program pursuant to sections 1 to 14, inclusive, of this act.

Sec. 16. (NEW) (*Effective from passage*) On or before September 1, 2009, the Department of Public Health shall expand the state's network of school-based health clinics so that all public school children in the state have ready access to such clinics. Such school-based health clinics shall be licensed by said department pursuant to chapter 368v of the general statutes and shall provide physical and behavioral health care, including dental care, with appropriate linkages to other services in the state. Such services shall include, but not be limited to, local health departments, community health centers, hospitals, social service providers, mental health and family service agencies, youth service bureaus, pediatricians and other primary care physicians and adolescent medical specialists.

Sec. 17. (NEW) (*Effective from passage*) (a) On or before July 1, 2009, the Department of Public Health shall establish sufficient primary care clinics to supplement other primary care resources so that all state residents shall have ready access to necessary primary care. Such primary care clinics shall be licensed by said department pursuant to chapter 368v of the general statutes and provide physical and behavioral health care, including dental care, with appropriate linkages to other services in the state, including, but not limited to, specialty care providers, other primary care providers and pharmacies. Each primary care clinic shall be, or be operated by, a federally qualified health center, a health center determined by the Commissioner of Public Health to be substantially similar to a federally qualified health center or a hospital. Each primary care clinic shall provide a wide range of primary care services and shall remain open outside of normal business hours to provide access to urgent but

nonemergency care.

(b) Licensed physicians and other health care providers who provide their services for a minimum number of hours to primary care clinics at a reduced rate shall receive incentives that may include, but need not be limited to, reduced cost medical malpractice insurance offered or arranged by the Department of Public Health, loan forgiveness from postsecondary educational institutions that receive funding from the state and partial payment of educational loans.

(c) The Commissioner of Public Health shall adopt regulations, in accordance with chapter 54 of the general statutes, to establish requirements for: (1) Services to be provided by and the hours of operation of primary care clinics; and (2) the provisions of services to primary care clinics by physicians and other health care providers, including the number of hours such services shall be provided.

Sec. 18. (NEW) (*Effective from passage*) (a) On or before January 1, 2008, and biennially thereafter, the Department of Public Health shall publish Plans For A Healthy Connecticut. The department shall develop each such plan with the assistance of state and local agencies, health care experts and members of the public. Each such plan shall include , but not be limited to, information pertaining to the following:

(1) Access to essential health care;

(2) Health care quality;

(3) Health care costs;

(4) Data collection and analysis needs;

(5) Health status and health care disparities, including those based on race, ethnicity, gender, age, sexual orientation, area of residence, health status, diagnosis, immigration status, education, employment, English-language fluency and other relevant factors between different groups of Connecticut residents; and

(6) Preserving wellness and preventing health problems.

(b) For each item listed in subsection (a) of this section, and for any other items included in the plan, the plan shall include:

(1) An assessment of the current status of such item in Connecticut;

(2) An analysis of recent public and private efforts to address such item;

(3) Recommendations for future public and private actions to address such item; and

(4) A statement of measurable goals and objectives, with defined time frames, that reasonably can be achieved given sufficient public and private sector commitment and resources.

Sec. 19. (*Effective from passage*) (a) There is established a Blue Ribbon Commission to study the Connecticut Select Care Choices program. Such study shall include, but not be limited to, an examination of the effect of such program on the cost of providing medical care in the state and the accessibility to medical care for residents of the state. Such commission shall develop recommendations for applying aspects of the program to the state residents who are served by the Medicare program.

(b) The commission shall consist of the following members:

(1) One each to be appointed by the Governor, the speaker of the House of Representatives, the president pro tempore of the Senate, the majority leader of the House of Representatives, the majority leader of the Senate, the minority leader of the House of Representatives and the minority leader of the Senate;.

(2) The Commissioner of Social Services, or said commissioner's designee; and

(3) The Comptroller, or said Comptroller's designee.

(c) Any member of the commission appointed under subdivision (1) of subsection (b) of this section may be a member of the General Assembly.

(d) All appointments to commission shall be made no later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(e) The member appointed by the Governor shall be the chairperson of the commission. The chairperson shall schedule the first meeting of the commission, which shall be held no later than sixty days after the effective date of this section.

(f) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to insurance shall serve as administrative staff of the commission.

(g) Not later than January 30, 2008, the commission shall submit a report on its findings and recommendations to the joint standing committees of the General Assembly having cognizance of matters relating to human services and public health, in accordance with the provisions of section 11-4a of the general statutes. The commission shall terminate on the date that it submits such report or January 30, 2008, whichever is later.

Sec. 20. (*Effective July 1, 2007*) The sum of ____ dollars is appropriated to the office of the Comptroller, from the General Fund, for the fiscal year ending June 30, 2008, for implementation of the Connecticut Select Care Choices program, established under section 2 of this act.

Sec. 21. (*Effective July 1, 2007*) The sum of ____ dollars is appropriated to the office of the Comptroller, from the General Fund, for the fiscal year ending June 30, 2008, for the purpose of lowering, by not less than ten per cent, the cost to employers of having employees and dependents receive health insurance coverage through the

Connecticut Select Care Choices program, established under section 2 of this act.

Sec. 22. (*Effective July 1, 2007*) The sum of ____ dollars is appropriated to the office of the Comptroller, from the General Fund, for the fiscal year ending June 30, 2008, for payment of reinsurance premiums for the Connecticut Select Care Choices program, established under section 2 of this act.

Sec. 23. (*Effective July 1, 2007*) The sum of ____ dollars is appropriated to the Department of Social Services, from the General Fund, for the fiscal year ending June 30, 2008, to develop and operate the information technology infrastructure required under section 8 of this act.

Sec. 24. (*Effective July 1, 2007)* The sum of ____ dollars is appropriated to the Department of Public Health, from the General Fund, for the fiscal year ending June 30, 2008, for the purpose of expanding the state's network of school-based health clinics, in accordance with section 16 of this act.

Sec. 25. (*Effective July 1, 2007*) The sum of ____ dollars is appropriated to the Department of Public Health, from the General Fund, for the fiscal year ending June 30, 2008, for the purpose of establishing primary care clinics, in accordance with section 17 of this act.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	New section
Sec. 2	*from passage*	New section
Sec. 3	*from passage*	New section
Sec. 4	*from passage*	New section
Sec. 5	*from passage*	New section
Sec. 6	*from passage*	New section
Sec. 7	*from passage*	New section

Sec. 8	*from passage*	New section
Sec. 9	*from passage*	New section
Sec. 10	*from passage*	New section
Sec. 11	*from passage*	New section
Sec. 12	*from passage*	New section
Sec. 13	*from passage*	New section
Sec. 14	*from passage*	New section
Sec. 15	*from passage*	New section
Sec. 16	*from passage*	New section
Sec. 17	*from passage*	New section
Sec. 18	*from passage*	New section
Sec. 19	*from passage*	New section
Sec. 20	*July 1, 2007*	New section
Sec. 21	*July 1, 2007*	New section
Sec. 22	*July 1, 2007*	New section
Sec. 23	*July 1, 2007*	New section
Sec. 24	*July 1, 2007*	New section
Sec. 25	*July 1, 2007*	New section

Statement of Purpose:

To ensure that Connecticut residents have adequate health care.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]